STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155732	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVEROAKS HEALTH CAMPUS	1244 VAIL ST PRINCETON, IN47670

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 4-8, 2011 Facility number: 004130 Provider number: 155732 AIM number: 200491050 Survey team: Sue Webster, RN- TC Diane Hancock, RN Census bed type: SNF/NF: 46 SNF: 14 Residential: 28 Total: 88 Census payor type: Medicare: 19 Medicaid: 21 Other: 48 Total: 88 Sample: 15 Supplemental sample: 4 Residential sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on April 12, 2011 by Bev Faulkner, RN			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure 3 of 3 supplemental sample residents reviewed, with allegations of physical and/or verbal abuse (Residents #9, #92, #93), in the supplemental sample of 4, were free of verbal abuse, in that allegations were made that the residents were verbally abused, and it was not disproved. (CNA #1, RN #2) Findings include: 1. Investigations of two allegations of verbal abuse were reviewed on 4/6/11 at 2:20 p.m. The first one occurred on	F0223	response not required	05/08/2011

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	7/29/10 at 12:20 p.m. The Director of Nurses [DON] received an allegation that CNA #1 cussed in the residents' presence, was rude and used offensive language. The residents involved were Resident #92 and Resident #9. The facility immediately suspended the CNA, and investigated the allegation through interviews of staff and residents. The Administrator was notified and the state agency notified in accordance with the facility policy. The residents were assessed with no signs or symptoms of physical or psychosocial harm. The DON was interviewed on 4/6/11 at 3:00 p.m. She indicated a CNA had written a letter to her alleging that CNA #1 had been rude to Resident #92, refusing to go look for a snack for the resident. The CNA also had alleged CNA #1 cursed in front of residents. The letter also alleged that CNA #1 did not talk nice to Resident #9. Resident #9 confirmed on interview that there was a night shift CNA who did not talk nice to him. After interviewing the residents, other residents, and staff who worked with the CNA, they could not disprove the allegation and CNA #1 was terminated for the allegation of verbal abuse. 2. The second allegation was dated 12/5/10 at 1600 [4:00 p.m.]. An LPN had			

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	reported to the facility social worker that RN #2 had been unprofessional verbally to Resident #93. The social worker felt the report was potentially verbal abuse and immediately notified the DON. The Administrator was notified. The facility assessed the resident, with no evidence of physical or psychosocial injury. The RN was suspended immediately and the allegation was investigated. The DON was interviewed on 4/6/11 at 3:00 p.m. She indicated the LPN had reported she had heard RN #2 tell Resident #93 to shut up and then continued to talk about the resident and her frustration at the nurse's station, in front of the resident. Other residents and staff were interviewed with no negative impact. The RN was terminated due to her unprofessional verbal behavior toward the resident. 3. The policy and procedure for Prevention and Reporting of Suspected Resident/Patient Abuse and Neglect, dated 1/06, was provided by the Medical Records Employee on 4/4/11 at 11:00 a.m. The policy and procedure included, but was not limited to, the following: "...Implementation and monitoring consist of the following components: Screening, Training, Prevention, Identification, Protection, Investigation, and Reporting."			

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	"Verbal Abuse - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability." The facility had followed their policy. 3.1-27(b)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure 1 of 23 residents observed during the medication pass had received her medications according to the physician's orders, in that doses had been missed of an antibiotic. (Resident #34) Finding includes: On 4/6/11 at 2:08 p.m., LPN #2 was observed to administer Ampicillin 500 mg [milligrams] one capsule to Resident #34. LPN #2 indicated it was the last dose of the round of antibiotics. The medication card from the pharmacy was observed to	F0282	Resident # 34 suffered no ill effects and as stated in the 2567 completed the full antibiotic thereapy course after MD notification. completed 4-10-11All residents have the potential to be affected. Through initiation of in-services, med pass observation and monitoring will ensure correct procedures are followed for med administration.Systematic change is, antibiotics will be counted each shift to ensure a better accounting of doses and times ordered for administration.Licensed urses and QMAs will be inserviced on new process of antibiotic control as well as medication pass policy.DHS/Designee will audit	05/08/2011

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	have 6 capsules left. The Medication Administration Record was reviewed, at that time, and on 4/4/11, the 1400 [2:00 p.m.] and bedtime doses were not signed off as given. LPN #2 indicated the first few doses would have probably been given from the Emergency Drug Kit [EDK]. Resident #34's clinical record was reviewed on 4/6/11 at 2:17 p.m. A physician's order for Ampicillin 500 mg three times a day for 10 days had been received on 3/27/11 at 1930 [7:30 p.m.], for a total of 30 doses. LPN #2 provided EDK sign out slips, on 4/6/11 at 3:00 p.m., dated 3/27/11 and 3/28/11, indicating three complete doses had been obtained from the EDK. There was no accounting for the additional three doses which would have totaled the 30 doses ordered. On 4/7/11 at 3:45 p.m., the Director of Nurses [DON] indicated she thought they had gotten at least one more dose out of the EDK, but could not find a slip to verify it. She indicated the staff person who did not sign off the medications on 4/4/11 was being counseled, the physician had been notified of the medications not given according to the orders, and the		antibiotic control logs for all new orders timely administration and EDK use,administration records 3x/week for 30 days, then weelky for 30 days and monthly thereafter. Immediate counseling of nurse/Qma if necessary on proper procedure.Results of audits will be forwarded to Q.A. committee x6 months and quarterly thereafter.	

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	physician had extended the antibiotic for two more doses to get the missed doses. The policy for monitoring of medication administration, dated 2/1/10, was provided by the DON on 4/8/11 at 11:55 a.m. The policy included, but was not limited to, the following: Medication administration was monitored "to verify that the resident has received medications in accordance with the prescriber's orders and facility policy." 3.1-35(g)(2)			
F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to ensure 1 of 1 resident with a pressure sore, in the sample of 15, did not develop a pressure sore under an immobilizer. (Resident #17) Finding includes:	F0314	resident #17 has been assessed with careplan reviewed and assignment sheet updated as immobilizer has been discontinued. Staff that provide care to her have been in-serviced on her needs and wound condition.All residents with positioning devices have the potential to be affected by the	05/08/2011

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	1. During the initial tour, on 4/4/11 at 10:25 a.m., the Medical Record Clerk [MRC], an LPN, indicated that resident #17 had a wound on the lower leg that had been caused by a splint. The MRC indicated the resident currently had a wound vac to the area. The clinical record for Resident #17 was reviewed on 4/5/11 at 2:15 p.m. The record contained documentation of Resident #17 having been admitted to the facility on 1/21/11. The record contained diagnoses that included, but were not limited to, hip fracture with open reduction internal fixation, venous insufficiency, and peripheral neuropathy. The admission physician's orders, dated 1/21/11, contained the following orders: "weekly skin assessment 0= no skin impairment, 1= new area of skin impairment-see skin sheet, 2= existing area of skin impairment-see skin sheet." "(R) [right] knee immobilizer @ all x's [times] remove for bathing and skin care 6a- 6p and 6p to 6a." The Assessment Review and Considerations, dated 1/25/11, identified the resident had the following risk factors		alleged deficient practice. Inservices and changes in assingment sheet communication will ensure that ordered devices are removed and skin inspected daily.Systemic change will include assignment sheet stating the orderedschedule of device application instead of just the device.DHS/Designee will observe positioning devices 5 days a week x 30 days, then 2 devices per week x30 days, then 2 devices per month thereafter.Results of audits will be forwarded to the Q.A. committee monthly for 6 months thereafter.	

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	the could contribute to skin breakdown: "mobility impairment, lack of sensation/response to pain, past history and medical diagnosis." The Medication Record, dated 2/1-2/28/11, had documentation of staff initials that the knee immobilizer had been removed for bathing and skin care. The initials were placed in boxes for day shift, 6a- 6p, and night shift, 6p to 6a from 2/1-19/11. The weekly skin assessment had been identified by blocked off dates of 2/7/11 and 2/14/11. There were no initials to indicate the weekly skin assessment had been conducted on either of these dates The record contained a Skin Impairment Circumstance, Assessment and Interventions form, dated 2/13/11. The form indicated, on 2/13/11 at 1920 [7:20 p.m.], an unstageable pressure area had been noted on the resident's right posterior calf. The area was measured as length 8.7 cm [centimeters] width 2.3 cm depth blank. On 3/24/11 and 4/4/11, the resident was seen at a wound care center. The history and physical, dated 3/24/11, contained the following documentation: "...comes in			

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	today for a chief complaint of a right posterior calf wound. She states that has been there approximately 2 months." The measurements were length 65 mm [millimeters] [6.5. centimeters] width 22 mm [2.2 cm] and depth 3 mm[.3 cm]. On 4/4/11, the wound clinic added a wound vac to be used on the area. On 4/5/11 at 3:05 p.m., the record was reviewed with the Director of Nurses and the Medical Records Clerk [MRC]. The MRC was unable to locate any additional information about the removal of the splint and the assessment of the area. On 4/5/11 at 3:25 p.m., the MRC provided a copy of the Certified Nursing Assistant assignment sheet in use at the time the open area was observed. The assignment sheet identified that the immobilizer was to be in place at all times without any instructions to remove it. The area was observed on 4/8/11 at 9:00 a.m. The wound vac was removed and the area was observed to be clean with red granulation tissue and a small amount of yellow slough. On 4/8/11 at 11:30 a.m.. the DON provided the current copy of the facility guidelines for cast, splint and brace care			

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	[no date]. The interventions for the brace/splint use included but were not limited to: "Follow physicians order for removal of splints and braces, if physician orders allow splint or brace to be removed monitor for skin breakdown when removing or replacing.." 3.1-40(a)			
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure menus were followed to meet the nutritional needs of the residents, in that pureed vegetables contained too much water and the controlled carbohydrate diets received twice the entree the menu indicated. This affected 10 of 10 pureed diets served, and 2 of 3 controlled	F0363	No residents were found to have been effected by the alleged deficient practice.All residents have the potential to be effected by the alleged deficient practice. Through inservices and one-on-one competency checks with cook/chef staff members, staff will be educated regarding portion control, following menu for pureed items, and portion control.Systemic	05/08/2011

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	carbohydrate diets observed. Finding includes: On 4/7/11 at 10:20 a.m., Cook #1 was observed preparing pureed zucchini squash. He indicated he was pureeing for 10 servings and they had 10 residents on pureed diets. He was observed referring to a recipe for pureed squash and followed the recipe for 10 servings as follows: Using a 1/2 cup scoop without drain holes to scoop out the boiled zucchini and water, he filled a measuring container to the 1 quart and 1/2 to 1 cup mark. He was observed to attempt to drain some of the water from the vegetables by holding the scoop against the side of the pan. The zucchini squash was observed to be saturated with water and floating in the water. Cook #1 added 1/2 cup thickener to the vegetable/water in the food processor. He stated, "I don't need to add any water, it's already in there." The vegetables, water, and thickener were pureed and the product was placed in a steam table pan and covered. The recipe was observed at that time. The recipe indicated, for 10 servings, the following were to be blended: 1/2 cup water, 1 and 1/4 quart well drained squash, and 1/2 cup thickener.		change will be that no/minimal water will be used in the puree recipe, unless otherwise indicated by specific recipe/policy and that meal spreadsheets will have CCHO diet highlighted in areas that differ from Regular diet portions.DFS/Designee will observe/audit puree food item prep for 5 days per week for 30 days, then 2 times per week for 30 days, then 2 times per month for 30 days. DFS/Designee will observe/audit and adherence to spreadsheet for accurate servig/portion control for 5 days per week for 30 days, then 2 times per week for 30 days, then 2 times per month for 30 days.Results from audits will be forwarded to QA committee monthly for 6 months and then quarterly thereafter.	

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	On 4/7/11 at 12:30 p.m., Cook #1 indicated all the pureed diets had been served. The steam table pan with the pureed vegetables was observed and the leftover vegetables were measured. There were 2 plus servings of vegetables left after 10 had been served. Also on 4/7/11, at 11:40 a.m., the tray line was observed. Cook #1 was serving the meals. Two controlled carbohydrate diets were observed set up by Cook #1 and the Dietary Services Manager. The meals included, but were not limited to, one full portion of lasagna and four ounces of zucchini squash. A third controlled carbohydrate diet was observed being prepared. At that time, Cook #1 was interviewed regarding the menu for the controlled carbohydrate diets. He referred to the menu and indicated they were only supposed to receive 1/2 portion of lasagna. He then corrected the plate he was serving at that time. Review of the menus, during the meal observation on 4/7/11 at 11:40 a.m., indicated the controlled carbohydrate diets were to receive a half portion of lasagna. 3.1-20(i)(1) 3.1-20(i)(4)			

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